

Dependent Eligibility Certification Form

Subscriber Name: Dependent Name: Dependent Address: Dependent Address: Dependent Member ID #: Student & Dependent Certification 1. Is the child unmarried, a resident of Connecticut and not covered under another group health plan through the dependent's employer?								
Dependent Name: Dependent Address: Dependent Member ID #:				Gener	al Information			
Dependent Address: Dependent Member ID #:	Subscriber Name:					Policy #:		
Student & Dependent Certification 1. Is the child unmarried, a resident of Connecticut and not covered under another group health plan through the dependent's employer?	Dependent Name	:				Dependent	Date of Birth:	
Student & Dependent Certification 1. Is the child unmarried, a resident of Connecticut and not covered under another group health plan through the dependent's employer? YES NO 2. Is the child a full-time student at an accredited school? YES NO 3. If "YES", name and address of school in which dependent is enrolled: 4. Expected date of graduation (if this year): // // MO DAY YR Disability Certification 1. Is dependent now incapable of self-support because of a disability? YES NO 2. Age of dependent when disability occurred: // No 3. Nature of disability (Please provide as much detail as possible): 4. Prognosis (estimate months or years): // Shame and address of Primary Care Physician: // Shame and address of Primary Care Physician: // Date Signed AUTHORIZE RELEASE OF ANY INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE AND AUTHORIZE RELEASE OF ANY INFORMATION REQUEST IN REGARD TO THE CERTIFICATION. Subscriber Signature Date Signed Any person who includes any false or misleading information on an application for insurance commits a fraudulent insurance act and is subject to criminal and civil penalties. Please complete this form and return to the following: The Guardian Life Insurance Company of America, P.O. Box 981569, El Paso, TX 79998-1569 GG -015024-CTDTC STORIES ACCIDENT STOP LOSS	Dependent Addre	ss:						
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3. If "YES", name and address of school in which dependent is enrolled:			ent of Con	necticut	t <u>an</u> d not covered u		group health	plan
4. Expected date of graduation (if this year):	2. Is the child a fu	ll-time studen	t at an accr	edited s	school? YES	□no		
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DENTAL DISABILITY LIFE VISION CRITICAL ILLNESS CANCER ACCIDENT STOP LOSS	Company of America	, P.O. Box 98156	9, El Paso, I	X 79998-	-1569			
DENTAL DISABILITY LIFE VISION CRITICAL ILLNESS CANCER ACCIDENT STOP LOSS								
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